PNWF

[redacted]

PATIENT INFORMATION FORM

Demographics

Last Name [redacted]	First Name [redacted]	Middle Initial	Date of Birth [redacted]
Preferred Name	Preferred Pronouns	Sex Assigned at Birth	Gender Identity
Primary Language	Interpreter Needed (Y/N)?	Marital Status	
Street Address [redacted]		Apt/Ste [redacted]	
City	State/Province	Country (if not US)	Zip/Postal Code [redacted]
Cell Phone	Alternate Phone	Email [redacted]	
Employer Name	Employment Status	Occupation	
Emergency Contact Name [redacted]	Emergency Contact Number [redacted]	Relationship	

Disclosure Authority

I understand the risks involved with using unencrypted email and possible disclosure of Protected Health Information through use of unencrypted email. I choose to communicate with PNWF using (please make ONE selection):

____ Unencrypted Email (most common) ____ Encrypted Email (requires username and password)

If both or neither option is selected, then the default is to communicate using unencrypted email.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosures of my Protected Health Information as indicated below:

____ Self ____ Partner ____ Other Individuals

Partner's Name [redacted]	Partner's Date of Birth [redacted]
Other Individual	Relationship to Patient
Other Individual	Relationship to Patient

I authorize PNWF staff to leave a detailed voice message with the phone number on file Yes ____ No ____

I authorize PNWF staff to send text message reminders to the phone number on file Yes ____ No ____

If both or neither option is selected, then the default is messages are authorized.

RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

- I have received a copy of the PNW Fertility and IVF Specialists **Statement of Privacy Practices, Principles of Patient's Rights and Responsibilities,** and **Patient Responsibilities** which provide information about how my health information may be used and disclosed.
- Pacific Northwest Fertility and IVF Specialists reserve the right to change the privacy practices that are described in the **Statement of Privacy Practices.** If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

I have read the above and understand its contents: [redacted]
Initials

Signature: [redacted] **Date:** _____

Patient Rights and Responsibilities

Policy

It is the policy of the Practice to preserve the rights and responsibilities of every patient and adhere to the guidelines developed by the National Health Council as defined herein. Patients are informed of their rights and responsibilities prior to receiving care.

This policy does not presume to be all inclusive of incidents related to patient's rights and responsibilities. It is intended to express the Practice's commitment to maintain a professional relationship and to emphasize the need to observe the rights and responsibilities of the patient.

Procedures

These rights and responsibilities, such as the following developed by the National Health Council, are published and communicated to all patients:

PRINCIPLES OF PATIENT'S RIGHTS AND RESPONSIBILITIES
NATIONAL HEALTH COUNCIL

1. **All patients have the right to informed consent in treatment decisions, timely access to specialty care, and confidentiality protections.**

Patients should be treated courteously with dignity and respect. Before consenting to specific care choices, they should receive complete and easily understood information about their condition and treatment options. Patients should be entitled to coverage for qualified second opinions; timely referral and access to needed specialty care and other services; confidentiality of their medical records and communications with providers; and, respect for their legal advanced directives or living wills.

2. All patients have the right to concise and easily understood information about their coverage.

This information should include the range of covered benefits, required authorizations, and service restrictions or limitations (such as on the use of certain health care providers, prescription drugs, and "experimental" treatments). Plans should also be encouraged to provide information assistance through patient ombudsmen knowledgeable about coverage provisions and processes.

3. All patients have the right to know how coverage payment decisions are made and how they can be fairly and openly appealed.

Patients are entitled to information about how coverage decisions are made, i.e., How "medically necessary" treatment is determined, and how quality assurance is conducted. Patients and their caregivers should have access to an open, simple and timely process to appeal negative coverage decisions on tests and treatments they believe to be necessary.

4. All patients have the right to complete and easily understood information about the costs of their coverage and care.

This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, copayments, and additional premiums), and any catastrophic cost limits. Upon request, patients should be informed of the costs of services they've been rendered and treatment options proposed.

5. All patients have the right to a reasonable choice of providers and useful information about provider options.

Patients are entitled to a reasonable choice of health care providers and the ability to change providers if dissatisfied with their care. Information should be available on provider credentials and facility accreditation reports, provider expertise relative to specific diseases and disorders, and the criteria used by provider networks to select and retain caregivers. The latter should include information about whether and how a patient can remain with a caregiver who leaves or is not part of a plan network.

6. All patients have the right to know what provider incentives or restrictions might influence practice patterns.

Patients also have the right to know the basis for provider payments, any potential conflicts of interest that may exist, and any financial incentives and clinical rules (e.g., quality assurance procedures, treatment protocols or practice guidelines, and utilization review requirements) which could affect provider practice patterns.

To voice grievances or complaints contact:

Susan Christofferson, Administrator PNWF:	206-515-0000
Washington State Department of Health:	360-236-4700
Accreditation Association for Ambulatory Health Care, Inc:	847-853-6060

PATIENT RESPONSIBILITIES

1. **Provide complete and accurate information** to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.

2. **Actively participate in decisions about their health care**:
   - seek an annual medical examination when recommended for their age group
   - be present at all other scheduled health care appointments
   - provide accurate information to caregivers regarding their medical and personal histories and current symptoms and conditions
   - ask questions of providers to determine the potential risks, benefits and costs of treatment alternatives
   - where appropriate, this would include information about the availability and accessibility of experimental treatments and clinical trials
   - seek and read literature about their conditions and weigh all pertinent factors in making informed decisions about their care

3. **Participate in his/her care by cooperating fully with providers in following the mutually accepted treatment regimens:**
   - regularly reporting on treatment progress
   - informing providers of other medications and treatments they are pursuing simultaneously.
   - reporting to provider promptly If serious side effects, complications, or worsening of the condition occur,

4. **Provide a responsible adult to provide transportation home** from the facility and remain with him/her for 24 hours, when required by his/her provider.

5. **Become knowledgeable about their health plans, and accept personal financial responsibility for any charges not covered by their insurance.**

6. **Behave respectfully toward all health care professionals and staff, as well as other patients and visitors.**

7. **Pursue healthy lifestyles:**
   To the best of their ability and circumstances, patients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption and drug abuse.

PNWF

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protecting the privacy of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone—even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have the right to request copies of your healthcare information to request copies in a variety of formats and to request a list of instances in which we, our business associates, have disclosed your protected health information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by the law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.